# TRICARE PRIME ENROLLMENT APPLICATION AND PCM CHANGE FORM

**This form is for eligible beneficiaries who want to enroll in TRICARE Prime, TRICARE Prime Remote (TPR) and US Family Health Plan. This form is for new enrollments and Primary Care Manager (PCM) changes. This form may be used to request a PCM change within the same military treatment facility or civilian clinic or at a new facility or new TRICARE region. This form should be used to transfer enrollment within the 50 United States and Washington, D.C.**

**Review the eligible categories (1 through 4) below to determine the application sections you must complete.**
**If you are eligible to enroll (identified below), then complete the required sections:**

| Eligible Categories | Section I Sponsor Information | Section II Enrolling Family Members | Section III Other Health Insurance | Section IV Reason for PCM Change | Section V Signature | Section VI Enrollment Fee Payment |
|---|---|---|---|---|---|---|
| **1.** Active Duty Service Members, Reserve Component Members called or ordered to active duty for 30 days or more | X | | | Complete if changing PCM | | |
| **2.**Active Duty Family Members and Survivors of Active Duty (first three years in survivor status) | X | X | X | Complete if changing PCM | X | |
| **3.** Active Duty Family Members of Reserve Component Members called or ordered to active duty for 179 days or more. Must be eligible in DEERS | X | X | X | Complete if changing PCM | X | |
| **4.** Retirees, retiree family members, survivors, and eligible former spouses under 65 years of age who reside within the 50 United States or Washington, D.C. | X | X | X | Complete if changing PCM | X | X (Must include required payment) |
| **5.** ADFMs, Retirees, retiree family members, survivors and eligible former spouses 65 years or older and entitled to Medicare Part A. **(Applicable only to US Family Health Plan)** | X | X | X | Complete if changing PCM | X | X (If not enrolled in Medicare Part B) |

**GENERAL INSTRUCTIONS**:

1. Print all information in **ink**. Make sure the information is complete and accurate.

2. Ensure personal information matches information in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Defense Manpower Data Center Support Office at 1-800-538-9552 or refer to your name as printed on your military ID card.

**3.** There are two address fields for the sponsor and each family member. The Residence address block should be completed if it is known. If you haven't established a residence at the time you are completing this form, insert "To be determined." in the Residence address block and complete the "Mailing " address block. The "Mailing " address block is only to be completed if mail is to be sent to an address other than the residence address. If the "Mailing " address block is blank, all mail will be sent to the residence address. The addresses and telephone numbers you include on this form will update DEERS**.**

**It is very important that you update your personal information in DEERS whenever your residence address, mailing address or phone number changes. Please see # 2**

**above.**

4. Sign and date the application (Section V).

5. **Please keep a copy of the completed TRICARE Prime application/PCM change form for your records.**

6. **TRICARE Prime -** Active duty service members are required to enroll in Prime. Active duty family members, retirees and their family members are encouraged, but not required, to enroll in Prime.

7. **TRICARE Prime Remote (TPR)** is a program for active duty service members and their family members when the sponsor lives and works over 50 miles or one hour drive from a Military Treatment Facility (MTF) and the family member lives with the sponsor.

8. Submit completed Application/PCM Change form to the address below. If you are requesting a PCM change within the same MTF, submit the completed Application/PCM Change form to the local MTF. For enrollment or PCM changes in the **US Family Health Plan** please see number 12 below.

   [Contractor's Name]
   [Street Address]
   [City, State 99999-9999]

   **Applications can be mailed to the contractor identified above or dropped off at a TRICARE Service Center (TSC).** Contact the local TSC in person or call the telephone number listed below in number 8 to determine when your new or transferred enrollment will begin.

**9.** For information on the TRICARE Prime procedures, contact the TRICARE Office identified below or visit the TMA Website at www.tricare.osd.mil.

**10.** For enrollment assistance, please call [Contractor's Name] at 1-8XX-XXX-XXXX or FAX for OCONUS

11. **US Family Health Plan** is a TRICARE Prime enrollment option for eligible individuals and families who live in seven specific parts of the country: Seattle Washington, Cleveland, Ohio, Portland Maine, Brighton, Massachusetts, Staten Island, New York, Baltimore, Maryland, and Houston, Texas. The primary difference between other TRICARE options and the US Family Health Plan is that US Family Health Plan may be used by uniformed services retirees and their eligible family members who are age 65 or older.

12. For enrollment or PCM changes in the **US Family Health Plan**, submit the completed Application/PCM Change form to the US Family Health Plan address listed below.

    [US Family Health Plan]
    [Street Address]
    [City, State 99999-9999]

    **For questions regarding enrollment/PCM changes in the US Family Health Plan, contact the US Family Health Plan member services at [1-800-XXX-XXXX]**

**AGENCY DISCLOSURE STATEMENT**

Public reporting burden for this collection of information is estimated to average fifteen (15) minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0728-00008), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.
PLEASE DO NOT RETURN YOUR APPLICATION TO THE ADDRESS ABOVE.. SEND YOUR APPLICATION TO THE ADDRESS SHOWN ON THE APPLICATION INSTRUCTION SHEET.

**PRIVACY ACT STATEMENT**

(1) Authority: 5 USC 552a, 10 U.S.C. 1079 and 1086, 58 FR 45318, 65 FR 30966, May 15, 2000.
(2) Purpose: To evaluate eligibility for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (32 CFR 199.17).
(3) Uses: Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions. Appropriate disclosures may be made to other federal, state, local and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program.
(4) Disclosure: Voluntary; however, failure to provide information will result in the denial of enrollment.

# TRICARE PRIME ENROLLMENT APPLICATION AND PCM CHANGE FORM

(Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing this form.)

Form Approved
OMB No. 0720-0008
Expires

| *Check one box* | | Prime Enrollment | | Prime Remote Enrollment | | USFHP Enrollment | | PCM Change |
|---|---|---|---|---|---|---|---|---|

**SECTION I - SPONSOR INFORMATION**

| | | | | | |
|---|---|---|---|---|---|
| 1.Sponsor Social Security Number (SSN) _ _ | | | | | |
| 2. Date of Birth (YYYYMMDD) | | | | | |
| 3. Sponsor Name *(Last, First, Middle Initial) (Must match DEERS)* | | | | | |
| 4. Sponsor is: (X one) | | Active Duty | | Deceased (Go to Section II) | |
| | | Retired | | Former Spouse (Go to Section II | |
| 5. Residence Address (Street/P.O. Box, Apt No., City, State, ZIP Code) | | | | | |
| 6. Mailing Address *(If different than residence address)* | | | | | |
| 7. Sponsor Telephone Number (Include Area Code) Home: ( ) Work: ( ) | | | | | |
| 8. City and Country of Military Assignment (OCONUS Only) | | | | | |
| 9.Member's Unit and Unit Identification Code (UIC) *(if known)* | | | | | |
| 10. Zip Code of Work Address | | | | | |
| 11. E-Mail Address | | | | | |
| 12. Sponsor's Enrollment Status: *(Check one box)* | | New Enrollment | PCM Change | | Already Enrolled (go to section II) |
| 13. Sponsor Primary Care Manager (PCM) Preference: *(Honoring your preferences depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member Services for availability of PCMs.) Complete all that apply.* | | | | | |
| a. PCM Name and Address *(if known)* | 1st Choice | | 2nd Choice | | |
| b. PCM Specialty | | No Preference | | Family/General Practice | |
| | | Flight Medicine | | Internal Medicine | |
| c. Preferred PCM Gender | | No Preference | | Male | Female |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **1.** | a. Name (Last, First, Middle Initial) Must match DEERS | | | | | | |
| | b. Date of Birth (YYYYMMDD) | | | | | | |
| | c. Residence Address (Street/P.O. Box, Apt No., City, State, ZIP Code) ☐ Same as Sponsor | | | | | | |
| | d. Mailing Address *(If different than residence* address) ☐ Same as Sponsor | | | | | | |
| | e. Relationship to Sponsor | | Spouse | | Former Spouse | | Child |
| | f. Telephone Numbers (Include Area Code) Home: ( ) Work: ( ) *(If different from sponsors)* | | | | | | |
| | g. Primary Care Manager (PCM) Preference *(Honoring your preferences depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member Services for availability of PCMs.) Complete all that apply.* | | | | | | |
| | 1. PCM Name and Address *(Check box if same as sponsor* | 1st Choice ☐ Same as sponsor | | 2nd Choice ☐ Same as Sponsor | | | |
| | 2. PCM Specialty | | No Preference | | Family/General Practice | | Internal Medicine |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Flight Medicine | | Pediatrics | | |
| | 3. Preferred PCM Gender | | No Preference | | Male | | Female |

## REPEATED SPONSOR SOCIAL SECURITY NUMBER AND NAME

**SPONSOR INFO**

Sponsor Social Security Number (SSN) _ _

Sponsor Name *(Last, First, Middle Initial) Must match DEERS)*

**SECTION II – CONTINUED ADDITIONAL FAMILY MEMBER INFORMATION**

a. Name (Last, First, Middle Initial Must Match Deers

b. Date of birth (YYYYMMDD)

c. Residence Address (Street/P.O. Box, Apt No., City, State, ZIP Code) ☐ Same as Sponsor

d.Mailing Address (If different than residence address)

e.Relationship to sponsor (X one) ☐ Spouse ☐ Child ☐ Former Spouse

f. Telephone numbers Include Area Code) Home: ( ) Work: ( )

g. Primary care manager (PCM) preference *Honoring your preferences depends upon the availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member Services for availability of PCMs.) Complete all that apply.*

| | | |
|---|---|---|
| 1.PCM Name and Address *(if known)* | 1st Choice ☐ Same as Sponsor | 2nd Choice ☐ Same as Sponsor |

| | | | | | |
|---|---|---|---|---|---|
| 2.PCM Specialty | ☐ No preference | ☐ Family General Practice | ☐ Internal Medicine | | |
| | ☐ Flight Medicine | ☐ Pediatrics | | | |
| 3. PCM Gender | ☐ No Preference | ☐ Male | ☐ Female | | |

**SECTION II – CONTINUED ADDITIONAL FAMILY MEMBER INFORMATION**

a. Name (Last, First, Middle Initial) Must Match Deers

b. Date of birth (YYYYMMDD)

c. Residence Address (Street/P.O. Box, Apt No., City, State, ZIP Code) ☐ Same as Sponsor

d.Mailing Address (If different than residence address)

e.Relationship to sponsor (X one) ☐ Spouse ☐ Child ☐ Former Spouse

f. Telephone numbers Include Area Code) Home: ( ) Work: ( )

g. Primary care manager (PCM) preference *Honoring your preferences depends upon the availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member Services for availability of PCMs.) Complete all that apply.*

| | | |
|---|---|---|
| 1.PCM Name and Address *(if known)* | 1st Choice ☐ Same as Sponsor | 2nd Choice ☐ Same as Sponsor |

| | | | | | |
|---|---|---|---|---|---|
| 2.PCM Specialty | ☐ No preference | ☐ Family General Practice | ☐ Internal Medicine | | |
| | ☐ Flight Medicine | ☐ Pediatrics | | | |
| 3. PCM Gender | ☐ No Preference | ☐ Male | ☐ Female | | |

| REPEATED SPONSOR SOCIAL SECURITY NUMBER AND NAME | | | | | |
|---|---|---|---|---|---|
| SPONSOR INFO | Sponsor Social Security Number (SSN) _ _ | | | | |
| | Sponsor Name (Last, First, Middle Initial) Must match DEERS | | | | |
| OHI | **SECTION III -- OTHER HEALTH INSURANCE (OHI) COVERAGE** | | | | |
| | Are any enrolling family members or is the retiree sponsor currently covered by OHI ? (not a TRICARE Supplement)<br>**If yes, provide the name of the other health insurance and the insurance identification number.** | | No<br>Yes | | |
| | (Name of other health insurance) and (insurance identification number) | | | | |
| | **SECTION IV – REASON FOR PCM CHANGE** | | | | |
| REASON FOR PCM CHANGE | Reason for change<br>(X one per affected family member ) | | Move | | Other *(explain)* |
| | | | Move | | Other *(explain)* |
| | | | Move | | Other *(explain)* |
| | | | Move | | Other *(explain)* |
| SIGNATURE | **SECTION V—SIGNATURE** of the Sponsor, spouse or other legal guardian of the beneficiary | | | | |
| | I understand that it is my responsibility to comply with all required TRICARE Prime procedures. By signing the form, I certify that the information on this form is true, accurate and complete. Federal funds are involved in this program and any false claims, statements, comments or concealment of a material fact may be subject to fine and imprisonment under applicable Federal law.<br>Signature _____ Date Signed _____ | | | | |

| REPEATED SPONSOR SOCIAL SECURITY NUMBER AND NAME | | |
|---|---|---|
| SPONSOR INFO | Sponsor Social Security Number (SSN) _ _ | |
| | Sponsor Name (Last, First, Middle Initial) Must match DEERS | |

**SECTION VI – PAYMENT OF TRICARE PRIME ENROLLMENT FEES NOTE: <u>This Section is only for retirees, retiree family members, survivors and eligible former spouses.</u>** Retired beneficiaries enrolled in Medicare Part B may have their enrollment fees waived if they provide a copy of their Medicare card as proof of enrollment in Medicare Part B. Explain all split enrollments (retiree family enrollment in more than one TRICARE Region) on separate sheet of paper. Certain survivors of active duty members pay no enrollment fee during the first three years in survivor status.

| 1. **PAYMENT FEE OPTIONS** | | **MONTHLY** | | **QUARTERLY** | | **ANNUAL** |
|---|---|---|---|---|---|---|
| 2. **PLAN SELECTION** (X One) | | Single $19.17 | | Single $57.50 | | Single $230.00 |
| | | Family $38.34 | | Family $115.00 | | Family $460.00 |
| 3. **PAYMENT METHOD** (X One) | | a. Allotment for Retired Pay **(Complete A below)** | | a. Check/Cashiers Check/ Money Order* | | a. Check/Cashiers Check/ Money Order* |
| | | b.Electronic Funds Transfer **(Complete B below)** | | b. VISA or Master Card **(Complete C below)** | | b. VISA or Master Card **(Complete C below)** |

Note: **Quarterly** and **annual** bills will be sent on a quarterly and annual basis, respectively. **Monthly** bills will not be sent.

* Make check payable to the [Contractor's Name]

**A**

**MONTHLY ALLOTMENT**

I _____ choose to have my enrollment fees automatically paid by monthly
*(Signature of Sponsor)* allotment from my Uniformed Services retired pay.

*(NOTE: Only retired Uniformed Services members may establish an allotment from their retired pay)*

**B**

I _____ choose to have my enrollment fees automatically paid by monthly
*(Signature of Account Holder)* electronic funds transfer.

**ELECTRONIC FUNDS TRANSFER**

1. Name and Address of Financial Institution

2. Financial Institution's Telephone Number:

| 1. Account Information *(Check one box)* | | Savings |
|---|---|---|
| | | Checking (Attach Voided Check) |

4. Account Number

5. Bank or ABA Routing Number

6. Name on Account

**C**

I _____ choose to have my enrollment fees automatically billed to my credit card.
*(Signature of Card Holder)* (annual and quarterly payments only).

**CREDIT CARD**

1. Name on Credit Card

2. Credit Card Number
__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Expiration date (MMYY) __ __ __ __

| 3. Type of Credit Card | | VISA | | Master Card | |
|---|---|---|---|---|---|